Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 7, 2023

SOUTHLAKE REGIONAL HEALTH CENTRE

Ontario Health

OVERVIEW

Southlake Regional Health Centre (Southlake) is building healthy communities through outstanding care, innovative partnerships, and amazing people. We deliver a wide range of healthcare services to the communities of northern York Region and southern Simcoe County. Our advanced regional programs include Cancer Care and Cardiac Care and serve a broader population across the northern GTA and into Simcoe-Muskoka. We have also recently joined the provincial trauma initiative to help improve patient outcomes from trauma, and have been designated as one of the first Level III Trauma Centres in Ontario.

Our team of nearly 6,000 staff, physicians, volunteers, students and Patient and Family Advisors are committed to creating an environment where the best experiences happen. As a recognition of our commitment to quality and patient safety, we have received the highest distinction of Exemplary Standing from Accreditation Canada.

This is an open communication to the Patients and Families in our community who we exist to serve in fulfilling our four strategic goals to:
1. Forge a new path to meet the changing needs of our growing communities
2. Champion a culture of exemplary care and deliver clinical excellence
3. Create an environment where the best experiences happen
4. Own our role to improve the system

Our intent is to share our Quality Improvement Plan (QIP) in an open and transparent declaration of our pursuit of Quality and

Patient Safety for our patients, staff, and community. Thank you for taking the time to find and read our QIP. Every year, we create a new plan and post it publically; it is a part of our commitment to you. At Southlake, we are committed to continuously improving the quality and safety of the care we deliver to our patients and families and the work environment we provide to our staff, physicians, students, and volunteers.

For 2023/24, we have selected six indicators for our Quality Improvement Plan:

1. 90th Percentile ED Wait Time to Inpatient Bed
As a result of the pandemic, we are seeing unprecedented volumes in our Emergency Department. We also continue to see increased requirements for admissions, and ALC (alternate level of care) challenges. This is a measure of our timeliness in admitting patients coming through our Emergency Department. The “Wait” refers to the timeframe from when the decision is made to admit a patient, until the patient is physically on their way to an inpatient area. As we calculate the performance on this indicator, it tells us that 90% of our admitted patients wait less than this many hours.

2. Discharge Summaries within 2 Days
We are partners in a patient’s care journey, and we need to own our role to improve the system. As patients leave our hospital, it is important that their continuity of care be a priority. This is why we send Discharge Summaries to primary care providers, to ensure they have up-to-date knowledge of their patient’s health history while under our care. Our aim is to send these summaries within two days, for patients who spend longer than two days in hospital.

3. Patient Experience
We want to know if we are meeting your standards. This is why we ask, on a scale of 10, how your experience was while under our care. This indicator measures the percentage of respondents answering 9 or 10, out of all responses we receive. It helps inform us about what we can do better to meet your needs.

4. Workplace Violence Incidents Resulting in Lost Time or Healthcare
Our workforce, the people who care for you and help keep you safe, are our priority as well. It saddens us that they are often the target of violence in the workplace, which can result in a negative impact to their own health. Here, we measure the number of workplace violence incidents that result in lost time from work, or healthcare needed, for our own people.

5. Hospital Acquired Pressure Injuries at Prevalence
A pressure injury is an injury to the skin or underlying tissue caused by pressure, friction and moisture. These injuries often occur when patients have limited mobility and cannot change position in bed on their own. When pressure injuries occur, they must be treated quickly or they can damage the skin and underlying tissue, causing slow recovery, pain, infection and other problems. There are different stages of pressure injuries, but almost all pressure injuries are preventable.
On a single day each quarter, we assess a large sample of our inpatients (during a study called prevalence) to determine if they have any stage 2 or greater pressure injuries that they acquired while in hospital. These are called hospital acquired pressure injuries (or HAPI). Our goal is to never have any HAPIs, and Southlake continues to aims to reduce these.

6. Inpatient Falls Resulting in Moderate+ Harm
Mobilization is an important part of a successful recovery for many patients. It also helps with preventing pressure injuries. With mobilizing though, the risk of falling increases. We know that falls can and will happen while patients are in hospital. However, injuries from falls can be minimized by implementing best practice falls prevention guidelines. We continue to focus on minimizing falls resulting in serious harm, so here we measure the percentage of reported inpatient falls that result in moderate or higher harm.

We continue to grow a culture that embraces change and quality improvement. For our patients, staff, and community, we embrace continuous improvement in everything that we do.

PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

We engage and partner with our patients and their caregivers in multiple ways. Our Patient and Family Advisors (PFAs) participate on councils, committees, working groups, special projects and work in partnership with staff and physicians as discussions, plans, and decisions are being made about the delivery of healthcare services at Southlake with a co-design framework. Examples include: COVID Visitor policy, Emergency Department Paediatric Readiness Advisory Group, Surgical Quality Care Committee, PET/CT (Positron emission tomography/Computed Tomography) Planning Initiative for the Stronach Regional Cancer Centre, Goals of Care and Resuscitation Form Working Group, PICC Lines Handout, Southlake Navigator App, Ontario Cancer Plan 6 - Central Regional Cancer Program, Infection Control Committee, and Best Practice Guidelines Working Groups.

We also use surveys to ask for direct input from our patients. We have real-time surveys, which occur while patients are still in hospital, and surveys that occur after patients leave our hospital (administered by an external vendor). Asking patients directly about their needs, informs us on what we are doing well and where there are gaps. This helps to guide us in our improvement opportunities. Questions used on our external surveys come from reliable, validated and widely used patient experience surveys. The surveys gather information about patients' experiences during an inpatient visit/stay in relation to the following care dimensions:

- Coordination of care
- Information sharing
- Respect and dignity
- Discharge transition planning and management
- Responsiveness
- Overall hospital experience

In 2023, Southlake will be securing a new vendor to deliver our external surveys. Our PFAC will be engaged along the way to ensure we continue to ask the right questions, which will provide the most insight.

As it relates to Southlake's QIP development process, we received and incorporated feedback from our Corporate Patient Family and Advisory Committee (PFAC). In addition, our chair of the Corporate PFAC is a member of the Board Committee on Quality; a committee that has been continuously involved with the development of our QIP. Our drive to achieve our Quality Improvement Plan goals for 2023/24 will be supported in collaboration between dedicated staff, physicians, volunteers and patients/families.

PROVIDER EXPERIENCE

At Southlake, we understand the challenge that healthcare workers face on a daily basis. To support them, we will use the National Standard of Psychological Health & Safety in the Workplace as our guide to ensure that we are meeting the needs of our staff and providing them with mental health and wellness resources and programs.

In 2023, with a focus on psychological health and safety, we will be offering ongoing mental health and wellness seminars through our Employee Assistance Program (EAP) provider as well as through the Canadian Mental Health Association (CMHA) Your Health Space initiative. Our Organizational Development department continues to conduct regular pulse engagement surveys to help us identify opportunities for improvement. Results from these recent surveys have shown the need to focus on diversity, equity and inclusion, as well as civility and respect in the workplace. To answer these needs, we have brought on board a Diversity, Equity and Inclusion Director as well as an Organizational Culture Specialist. Our Human Resources (HR) department continues to take steps aimed at identifying opportunities for improvement in recruitment, retention, and overall workplace culture and experience. Examples of these steps include the implementation of the Recruitment and Retention Committee and the HR Process Improvement Steering Committee. Our Occupational Health, Safety & Wellness department has brought a dedicated Corporate Wellness Advisor on board and they continue to provide wellness initiatives and programs such as free membership to our onsite gym, in-unit wellness cart and engaging staff in wellness challenges and events. In addition, we intend to conduct a needs assessment through the Guarding Minds@Work Survey in 2023 to assess the specific needs of our organization in terms of Psychological Health & Safety.

WORKPLACE VIOLENCE PREVENTION

As part of our strategic priority to “create an environment where the best experiences happen”, Southlake is committed to addressing safety concerns of staff, physicians and volunteers; reducing the risk of workplace violence, and creating a safe environment for all.

Processes are in place to manage the risk of violence while ensuring safety for patients and staff. In the most immediate past, many staff, and all of our most at-risk staff, have completed Crisis Prevention Intervention (CPI). We have actively transitioned to a comprehensive Workplace Violence Training by SMG, where the same priority groups are slated to receive training while we continue to see compliance rates rise. We have also engaged in simulation exercises with York Region EMS and York Regional Police followed by debriefing exercises. Additional strategies in place include:

- Signage displayed throughout the hospital describing our “zero tolerance” of workplace violence
- Risk assessments, corporately annually, and in specific areas when there are changes
- Security controlled entry for patients and visitors accessing the Emergency Department
- Patient assessment at registration for a history of, or risk of violence, using a standardized violence assessment tool
- Unique displays on our patient tracking board if there is a risk for violence
- Safety pendants worn by all staff, which provide immediate alerts to security (identifying the location and staff at risk) when pressed

- Conducting a needs assessment for gaps in early intervention programs to address incivility

Despite the strategies above, incidents of violence still unfortunately occur. We have a robust incident reporting and investigation process, as it relates to workplace violence incidents. We monitor these incidents and analyze information, including security response time, and severity of incidents and then proactively engage with our leadership team to effectively strategize as necessary. Summary data on incidents of workplace violence is shared through various forums, including our Governance and People Committee of the Board, as well as our Board Committee on Quality. Additionally, our staff and our Joint Health and Safety Committee (JHSC) are very engaged in careful and inclusive reporting, investigation, proactive risk assessments, and analysis of incidents.

By working together to keep everyone safe, we strive to create an environment where the best experiences happen.

PATIENT SAFETY

Patient Safety is a top priority at Southlake, as we aim to “champion a culture of exemplary care and deliver clinical excellence”, while we also “create an environment where the best experiences happen”. To do this, we aim to learn and improve from all patient safety incidents.

As previously mentioned, we have a robust electronic incident reporting system that allows our front line staff to report patient safety incidents (along with other types of incidents). As incidents are reported, notifications are sent to appropriate people (including Clinical Managers and Educators, Directors, Senior Leadership, Quality, Risk, Privacy, Occupational Health, etc.), promoting immediate response, timely follow-up, investigation, awareness, and support of the people involved including our patients and families. Staff submitting an incident report have access to view the status of their incident report, as well as the outcome and actions taken as a result. This helps us to close the loop for our people.

For incidents resulting in severe harm or death, disclosure to patients and/or their substitute decision maker (SDM) is one of the first steps on our process. A comprehensive review then takes place, where we aim to understand the root causes for incidents. As part of our reviews, we embrace a culture of learning, and engage and empower our people through our Just Culture Policy. We take a systems approach when reviewing patient safety incidents, rather than focusing on individuals within the system. Once root causes are identified, recommendations are developed and presented at our Quality of Care Committee. On this committee, we have members from senior leadership, physicians, professional practice, patient experience, risk and quality. This cross-functional team allows for wholesome discussion and organizational impact. If and when there are learnings that could prevent future recurrences in other areas of the organization, this Committee discusses the optimal way to disseminate broadly. Recommendations developed through this process are shared with patients and/or their SDM when requested.

In 2022, Southlake introduced two new additional mechanisms to support and promote safety in the organization:
1. Daily Safety Call
2. Quality of Care Teleconferences

The Daily Safety Call is a 15-minute meeting with all leaders in the organization, where attendees have an opportunity to raise safety concerns that have the potential to affect operations for the following 24 hours and require resolution. Urgent issues are taken offline with the appropriate stakeholders engaged. Leaders then follow-up and thank their staff for bringing issues forward. This daily call promotes timely resolution and follow-up on our most pressing issues impacting safety for that day.

The Quality of Care Teleconference, launched in June 2022, is an opportunity to share immediate learnings regarding our most serious patient safety incidents. Ideally within one business day of an incident occurring, a team will meet to:

1. Collectively share what is known about the incident so far
2. Ensure appropriate immediate actions have been/will be taken
3. Decide if a review is required, and at what level
4. Determine next steps and owners.
5. Check in with the team to ensure everyone involved has been offered support, including patient/family, staff and healthcare professionals
6. Confirm the disclosure process has started, if appropriate

The teleconference promotes timely triggers for our Quality of Care review process, and is another mechanism to ensure our Leaders have clear oversight and can support improvement efforts on safety issues as they occur.

HEALTH EQUITY

Southlake celebrates, embraces, and supports diversity, equity, and inclusion in everything that Southlake does. We strive to support the reduction of health inequities and improve access to quality care for all patients by addressing the social determinants of health. We want to ensure patients and families feel Southlake is an accessible, welcoming, safe environment free of harassment and discrimination. In 2022, we launched the addition of patient pronouns in our health information system, along with partnering hospitals Oak Valley Health and Stevenson Memorial Hospital. Understanding and recognizing gender identities is important to delivering inclusive, patient-centered care. Using pronouns correctly is a sign of safety and respect; an environment all three organizations strive to achieve.

Additionally, we offer interpretation and translation services to facilitate effective communication between patients and care providers. We collect utilization data by language to better understand the community we serve, as well as religious and faith-based data to help facilitate spiritual services. By investing in our programs, we offer a variety of options to our patients that are more accessible and timely.

We “own our role to improve the system” by collaborating with our local indigenous community to better understand their experience at Southlake. We provide ongoing cultural competency training and explore opportunities to improve patient care for our indigenous patient population. We look forward to continuing collaborating and working with the communities we serve to address health disparities.

EXECUTIVE COMPENSATION

Our executives play important leadership roles in driving quality improvements efforts, and they help enhance accountability for delivery of our quality improvement priorities. As such, a portion of their annual compensation is directly linked to achieving the targets set out in our Quality Improvement Plan, through a performance-based compensation model. All six indicators on the 2023/24 QIP are linked to executive compensation, and equally weighed.

The executive team members at Southlake include:
- President and Chief Executive Officer
- Chief of Staff
- Vice President Patient Experience & Chief Nursing Executive
- Executive Vice President, Clinical Services & Regional Vice President, Cancer Services, Central Cancer Program, Ontario Health (Cancer Care Ontario)
- Vice President, Facilities & Business Develop
- Vice President, Strategy, Analytics and Communications
- Vice President, Finance & Digital Health and CFO
- Vice President, Employee Experience and Chief Human Resources Officer
- Vice President, Medical Affairs

CONTACT INFORMATION

For QIP inquiries, please contact:
Sabina Sabo, Director of Quality, Risk, and Privacy
T: 905-895-4521 Ext. 6611
S2Sabo@southlakeregional.org

OTHER

Quality improvement is an endless journey. At Southlake, we continue to embrace change as we strive to provide the best experience and outcome for everyone. Thank you for taking the time to read our Quality Improvement Plan.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 23, 2023

Board Chair, Patrick Horgan.

Board Quality Committee Chair, Marilee Harris

Chief Executive Officer, Arden Krystal

Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Discharge Summaries within 2 Days: Percentage of patients (who have a Family Provider noted in their Health Record) discharged from hospital for which discharge summaries are sent to their primary care provider within 2 days of discharge.	C	% / Other	Hospital collected data / Current Performance based on 2022 calendar year (Jan. 1 - Dec. 31, 2022). Date range for Target is 2023/24 fiscal year.	85.70	90.00	With a targeted focus on one to two specific Programs, we are aiming to improve our overall corporate performance to 90%. This is higher than our historical performance in any previous year.	

Change Ideas

Change Idea #1 Find and remove bottlenecks relating to preparing Discharge Summaries within two days of discharge

Methods	Process measures	Target for process measure	Comments
Through a Physician champion in our Surgical Program, investigate individual barriers to timely completion of the Discharge Summaries and develop improvement strategies to address.	Overall performance in our Surgical Program.	Increase performance in the Surgical Program from 55% to 76% within 2023/2024.	We have identified that our Surgical Program has the greatest opportunity for influencing improvement on this indicator. To increase the overall organizational performance this year, we will focus improvement efforts within this Program.

Change Idea #2 Find and remove bottlenecks in identifying primary care providers

Methods	Process measures	Target for process measure	Comments
Review processes relating to collection and documentation of Primary Care Providers, to identify barriers to populating this field in patient health records.	% of inpatients who have a primary care provider listed in their health record.	Relative improvement of 5% by end of 2023/2024.	A Discharge Summary is sent to a primary care provider, only when: 1. The primary care provider is known and documented in the health record, and 2. The Discharge Summary has been completed. It has been identified that approximately 12% of our inpatients do not have a primary care provider listed in their health record. The focus of this change idea is to increase the overall number of Discharge Summaries sent, by understanding and addressing barriers to condition #1 above. This is not expected to improve the overall performance measure, but is anticipated to increase the total number of patients whose Primary Care Provider receives a Discharge Summary.

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th Percentile ED Wait Time to Inpatient Bed: 90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department for admission.	C	90th percentile / All inpatients	CIHI NACRS / Current Performance based on 2023 fiscal year to-date (Apr. 1 - Dec. 31, 2022). Date range for Target is 2023/24 fiscal year.	33.00	31.50	20/21 and 21/22 performance and inpatient census was not indicative of pressures beyond the pandemic. Performance was only under 31.5 hours in two of the last nine months (22/23 to-date). It would be a stretch goal to reach and consistently maintain under 31.5 hours in 2023/24.	

Change Ideas

Change Idea #1 Develop contingency plans			
Methods	Process measures	Target for process measure	Comments
Create a working group that will develop and implement an effective corporate surge plan that is process driven, transparent and standardized.	Working group project milestones	100% complete by June 2023	As part of the Patient Flow Steering Committee this has been identified as one of this four priority areas of focus for improving patient flow. A working group will be created to focus on this initiative.

Change Idea #2 Standardize our admission and transfer process			
Methods	Process measures	Target for process measure	Comments
Create a working group that will develop standard documents with common language outlining expectations for the entire organization around admission and transfer.	Working group project milestones	100% complete by June 2023	As part of the Patient Flow Steering Committee this has been identified as one of this four priority areas of focus for improving patient flow. A working group will be created to focus on this initiative.

Change Idea #3 Standardize our discharge process			
Methods	Process measures	Target for process measure	Comments
Create a working group that will develop and implement an effective and efficient standardized discharge process that begins at admission.	Working group project milestones	100% complete by June 2023	As part of the Patient Flow Steering Committee this has been identified as one of this four priority areas of focus for improving patient flow. A working group will be created to focus on this initiative.

Change Idea #4 Find and remove discharge bottlenecks relating to Diagnostic Imaging

Methods	Process measures	Target for process measure	Comments
Increase predictability of inpatient scheduling of imaging and decrease variability of access based on time of day/week and addition of off-hours capacity.	Working group project milestones	100% complete by June 2023	As part of the Patient Flow Steering Committee this has been identified as one of this four priority areas of focus for improving patient flow. A working group will be created to focus on this initiative.

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient Experience: Percentage of respondents answering 9 or 10 when asked to rate their hospital experience/care/ stay, where 0 is the worst and 10 is the best.	C	% / Survey respondents	Other / Current Performance based on last year of data available (2021/2022). Date range for Target is 2023/24 fiscal year.	66.00	67.00	Data unavailable from 22/23. Continue with 22/23 target for 23/24, which was based on the following justification: 21/22 target (67%) not consistently met in 21/22, and current YTD is lower than target. Continue with 21/22 target for 22/23.	

Change Ideas

Change Idea #1 Listen to the patient's voice by actively seeking their feedback.

Methods	Process measures	Target for process measure	Comments
Use patient experience surveys to hear the concerns of the customer, and target improvement efforts accordingly.	Complete the procurement process of selecting a new external vendor to perform patient experience surveys, and begin collecting data.	Have a process in place to seek, collate, and analyze patient experience data in 2023/2024.	Southlake is currently in the procurement process for a new vendor to complete our external Patient Experience Surveys. As with many other local hospitals, the contract with our previous vendor ended March 31, 2022, and there have been challenges in the procurement process that needed to be overcome. The new vendor is expected to be operational in 2023/24.

Change Idea #2 Enhance the overall patient experience through focus on standard work and teamwork			
Methods	Process measures	Target for process measure	Comments
Increase number of units implementing the standardized approach to Collaborative Care Redesign (CCR)	% of inpatient units with CCR implemented.	100% of inpatient units within scope of CCR, implementing CCR by fiscal year end	CCR includes standard work relating to Team Zones, Care Boards, Team/Huddle, Bullet Rounds, Purposeful Hourly Rounding, and Bedside Shift report. To date, CCR has been fully rolled out on two inpatient units, and three more are in progress. The planned scope for CCR in fiscal year 2023/24, includes implementation on 14 inpatient units.

Change Idea #3 Strategically recruit members for our Patient and Family Advisory Committees (PFACs) to be inclusive and represent the populations we serve			
Methods	Process measures	Target for process measure	Comments
Address the gaps identified during an environmental scan, to increase the proportion of our diverse participants on our PFACs	Increase the number of diverse patient and family advisors on our PFACs	Double our participation on PFACs for underrepresented groups	Patient Family and Advisory Committees (PFACs) represent the patient's voice, and help co-design our processes. During COVID, our PFAC bodies were scaled down. For fiscal year 2023/24, we will re-build our PFACs for all our clinical programs (Surgery, Cardiac, Medicine, Cancer, Mental Health, Emergency Department, and Maternal Child).

Change Idea #4 Enhance the patient experience for our Senior Population			
Methods	Process measures	Target for process measure	Comments
Develop and implement a senior-friendly strategy	% of senior-friendly initiatives identified that are implemented	100% by end of fiscal 2023/24	Initiatives for senior population may include re-instating the Hospital Elder Life Program (HELP) and Senior Friendly Mobility Campaign

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Workplace Violence Incidents Resulting in Lost Time or Healthcare: Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period, that result in Lost Time or Healthcare	C	Count / Worker	In house data collection / Current Performance based on 2022 calendar year (Jan. 1 - Dec. 31, 2022). Date range for Target is 2023/24 fiscal year.	31.00	26.00	Achieve and maintain best historical annual performance from last 2 years, which is based on data from SafePoint. Prior year's data comes from a different source (Parklane). Including some Q4 data, current YTD count is 27 incidents with lost time or healthcare. The year-end performance may be higher than the projected 32, so 26 will be an improvement from this year.	

Change Ideas

Change Idea #1 New corporate training initiatives to include workplace violence, patient handling and supervisor competencies

Methods	Process measures	Target for process measure	Comments
Extending SMG training to all areas through the new hybrid model and collaboration with allied health to deliver the new safe patient handling training to all clinical areas.	% of staff completing/attending the training will be measured through internal reporting mechanisms.	Frontline staff for all clinical areas to achieve 100% compliance in these training initiatives before Dec 31, 2023.	In 2022, the focus for training was on high risk areas only. Given the high compliance rates in those areas, the focus will now shift to all areas.

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Hospital Acquired Pressure Injuries at Prevalence: Percentage of patients with a new stage 2+ hospital acquired pressure injury (HAPI) identified during the quarterly pressure injury prevalence study.	C	% / Other	In house data collection / Current Performance based on 2022 calendar year (Jan. 1 - Dec. 31, 2022). Date range for Target is 2023/24 fiscal year.	8.90	7.00	Over the past three years, our HAPI prevalence performance has been increasing, and averaged 9.1% from 19/20 to 21/22. For 2023/24, we are setting a stretch target for this indicator; approximately a 20% improvement from the last four quarters (baseline).	

Change Ideas

Change Idea #1 Synchronize quality improvement efforts through a coordinated and collaborative interprofessional approach

Methods	Process measures	Target for process measure	Comments
Re-launch the Skin and Wound Committee to generate and guide improvement strategies	Form committee and meet regularly	Committee will meet a minimum of 10 times within the 2023/24 fiscal year	Improvement strategies discussed in committee may include replacement of brown pads with a different product, linen algorithm, reduction of use of briefs, etc.

Change Idea #2 Invest more capital resources, to increase the use of Pressure Injury Prevention Interventions

Methods	Process measures	Target for process measure	Comments
Procure equipment to enhance patient care as it relates to pressure injury prevention.	Obtain additional beds with air surfaces, mechanical lifts, and patient transfer devices	Receive at least 80% of requested equipment.	Specialized beds with air surfaces, mechanical lifts, and patient transfer devices are all pieces of equipment that can help prevent and reduce pressure injuries. It has been identified that our existing capital resources do not meet the full demand for this equipment, so we have initiated the procurement process to purchase more.

Measure

Dimension: Safe

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient Falls Resulting in Moderate + Harm: Percentage of reported inpatient falls that result in moderate or higher harm (as a proportion of all inpatient falls and near-miss falls reported).	C	% / All inpatients	In house data collection / Current Performance based on 2022 calendar year (Jan. 1 - Dec. 31, 2022). Date range for Target is 2023/24 fiscal year.	2.30	1.60	22/23 target was not consistently met quarterly, and current YTD is not meeting target. Continue with 22/23 target for 23/24, to try to achieve stretch goal.	

Change Ideas

Change Idea #1 Improve the accuracy of Falls Risk Assessments			
Methods	Process measures	Target for process measure	Comments
Roll out the Johns Hopkins Falls Risk Assessment Tool	Tool will be embedded into the electronic medical record (EMR) and education will be provided to clinical staff related to how to use the tool.	The new tool will be used in all adult inpatient medical & surgical units in the hospital.	The Johns Hopkins tool is a validated tool that will help the staff easily recognize patients who are at low, medium or high risk of falls.
Change Idea #2 Invest more capital resources, to increase the use of Falls Prevention Interventions			
Methods	Process measures	Target for process measure	Comments
Procure equipment to enhance patient care as it relates to falls prevention.	Obtain additional beds with bed exit alarms, mechanical lifts, and patient transfer devices	Receive at least 80% of requested equipment.	Specialized beds with exit alarms, mechanical lifts, and patient transfer devices are all pieces of equipment that can help prevent and reduce injury from falls. It has been identified that our existing capital resources do not meet the full demand for this equipment, so we have initiated the procurement process to purchase more.
Change Idea #3 Improve communication of falls risk during transfers of accountability			
Methods	Process measures	Target for process measure	Comments
Include falls risk in transfer of accountability at shift change	Roll out the Electronic Handover Report to inpatient units	Roll out the Electronic Handover Report to all adult inpatient Medical/Surgical units by end of 2023/24	The Electronic Handover Report is a tool to help guide nurses in their communication at handover, regarding falls risk, among other pertinent clinical information and potential safety concerns.